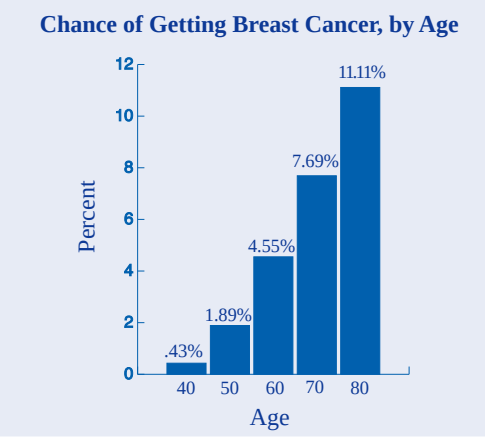
HCFA MEDICARE • MEDICAID Health Care Financing Administration

Volume V, Number 10 July 2000

HEALTH watch

Medicare Will Help Pay For Mammograms

The Balanced Budget Act of 1997 expanded the Medicare coverage of screening mammograms from once every other year to once a year for women over the age of 40 who are enrolled in Medicare. Medicare pays 80 percent of the approved amount for a screening mammogram and the patient must pay the remaining 20 percent.



By age 40, a woman's chances of getting breast cancer is 1 out of 233; by age 50, it's 1 out of 53; by age 60, it's 1 out of 22; by age 70, chances are it's 1 out of 13; and by age 80, 1 out of 9. Research also shows that older women do not recognize that advancing age is the strongest risk factor for breast cancer, even stronger than family history.

Women who would like more information about breast cancer prevention, screening and treatment can contact NCI's Cancer Information Service at 1-800-4-CANCER or visit their Internet web site at ***http://www.nci.nih.gov***. Medicare information is available 1-800-MEDICARE (1-800-633-4227), or at ***http://www.medicare.gov/.***

Medicare Asks Doctors, Suppliers and Home Health Agencies to Help Ensure Accurate Payment and Simplify Requirements

Medicare's top official is sending letters to more than 800,000 physicians, suppliers and home health agencies asking for their help in assuring that Medicare pays correctly for their services.

In the letters, Nancy-Ann DeParle, Administrator of the Health Care Financing Administration, cites some common payment errors and urges doctors and other providers to prevent such errors by providing adequate documentation.

The letters are the latest step in the agency's on-going efforts to pay providers correctly while preventing waste, fraud and abuse in the Medicare program.

Medicare's payment error rate, as estimated by the HHS Inspector General, was 7.97 percent in Fiscal Year 1999—nearly half of the 14 percent estimate for Fiscal Year 1996, the first year of the audit. HCFA continues to work to meet its long-range Government Performance Review Act goal of 5 percent error rate by Fiscal Year 2002.

In the letters, DeParle highlights some of HCFA's on-going efforts, such as:

1. Requiring the private companies that process Medicare claims to implement toll-free hotlines in the fall to answer questions from physicians and other providers about proper billing and other issues.

2. Testing new evaluation and management guidelines that will reduce the burden on physicians while ensuring fair and consistent medical review.

3. Measuring and identifying payment errors for each Medicare claims-processing contractor to better target education campaign and other efforts at further reducing Medicare's payment error rate.

Although Medicare pays virtually all claims correctly based on the information submitted, improper payments occur for reasons such as insufficient documentation, lack of medical necessity, and improper coding by providers.

Since the Inspector General's first comprehensive audit, HCFA has taken many steps to modernize Medicare's accounting systems, to strengthen oversight of the private companies that process claims, and to ensure proper payment for Medicare services.

The letters were sent the first week in June to 660,000 physicians and group medical practices, 140,000 durable medical equipment suppliers, and 9,000 home health agencies. Text of the letter is on HCFA's web site at ***www.hcfa.gov/medicare/mip/cfolettr.htm.***

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

MISSION —We assure health care security for beneficiaries.
VISION — In the stewardship of our programs, we lead the Nation's health care system toward improved health for all.
GOALS — Protect and improve beneficiary health and satisfaction • Promote the fiscal integrity of HCFA programs • Purchase the best value health care for beneficiaries • Promote beneficiary and public understanding of HCFA and its programs • Foster excellence in the design and administration of HCFA's programs • Provide leadership in the broader public interest to improve health.
OBJECTIVES — ***Customer Service*** • Improve beneficiary satisfaction with programs, services and care • Enhance beneficiary program protections • Increase the usefulness of communications with constituents, partners, and stakeholders • Ensure that programs and services respond to the health care needs of beneficiaries.
Quality of Care • Improve health outcomes • Improve access to services for underserved and vulnerable beneficiary populations • Protect beneficiaries from substandard care.
Program Administration • Build a high quality, customer-focused team • Enhance program safeguards • Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds • Increase public knowledge of the financing and delivery of health care • Improve HCFA's management of information systems/ technology.

You may browse past issues of the *HCFA Health Watch* at ***www.hcfa.gov/publications/newsletters/healthwatch/***. Also, should you wish to make an address change or comment on an article, send your E-mail to ***healthwatch@hcfa.gov***.

Message from the Administrator

NANCY-ANN DEPARLE

HCFA has taken a major forward step in its ongoing efforts to ensure that doctors receive fair and accurate compensation for the essential services that they provide to more than 39 million elderly and disabled Medicare beneficiaries.

We are pilot-testing new, simplified documentation guidelines for physician visits. After pilot-testing these simplified guidelines for evaluation and management services, HCFA will replace current ones.

As I advised doctors in a *JAMA* article in June, "These guidelines are important because a properly documented record is essential to good clinical care. It eases communication and coordination among physicians and other health care professionals."

Proper documentation also ensures that taxpayer dollars are spent in accordance with the law and that the level of services in a submitted claim was in fact the level provided.

Unfortunately, this has not always been the case. A congressionally mandated audit of fiscal year 1999 Medicare claims by the HHS Inspector General attributed $5.5 billion in improper payments to inadequate or non-existent documentation.

In 1995, working with the American Medical Association, we developed E&M guidelines and updated them in 1997. But the results have not been satisfactory. Many physicians have told us that the 1997 guidelines were cumbersome to use in actual practice. The 1999 IG report confirmed what many physicians already knew — we needed better, simpler, clearer documentation guidelines.

That is why HCFA, including Center for Health Plans and Providers Director Robert Berenson, M.D., Paul Rudolf, M.D., and Barbara Paul, M.D., went back to the 1995 version, which was more agreeable to the medical community to start over. They had three goals in mind: simplify the guidelines; reduce the burden; and foster consistent and fair medical review.

The result is guidelines that seek to minimize "counting" — the need for physicians to count elements of their services — and include a series of scenarios for physical examinations and medical decision-making to assign an appropriate service level.

A second version, that also will be pilot-tested, focuses more on how physicians make medical decisions and less on history and physical examination. This version involves little or no counting.

Throughout the testing process, HCFA will develop comprehensive education materials to help physicians use the new guidelines effectively and efficiently. HCFA plans to use a range of training approaches and materials during the pilot tests and maintain an array of the most effective training options when new guidelines are put in place nationally.

HCFA will seek physician advice throughout the process and will make appropriate changes based on the pilot tests' results, which should be available next year. New guidelines could be in place as early as 2002.

Already HCFA has held a town hall meeting for further discussion and to get feedback from physicians before moving into the testing phase.

Physicians helped develop these guidelines, and we want physicians to tell us whether the revisions being tested are, in fact, better for them in the real world of day-to-day clinical practice. Working together, we can have a simpler, clinically meaningful, and non-intrusive approach to documentation that works for patients, the doctors who care for them, and taxpayers.

Selected Health Issues on the *Web*

http://www.gao.gov/new.items/he00121t.pdf

DOD and VA Healthcare: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars
T-HEHS-00-121, May 25, 2000

Stephen P. Backhus, Director of Veterans' Affairs and Military Health Care Issues, discusses what the Department of Veterans Affairs (VA) and Defense (DOD) have done and what more they could do to reduce drug prices and dispensing costs. In Fiscal Year 1999, VA and DOD together spent about $2.4 billion — or about 2 percent of all domestic drug sales — for about 140 million prescriptions for veterans and for active duty and retired military and their families. Recently, soaring drug costs have focused attention on the merits of having the agencies procure their drugs jointly, and better manage their pharmacy operations.

http://www.gao.gov/new.items/he0096.pdf

Women's Health: NIH Has Increased Its Efforts to Include Women in Research
HEHS-00-96, 29 pp. plus 5 appendices of 8 pp, May 2, 2000

In the 1980s, public health leaders and advocates drew attention to inequities in health research and the fact that particular women and minorities were being excluded from research studies. Many of the major research studies the National Institutes of Health (NIH) funded included only men, making it uncertain whether the studies' results applied also to women.

http://www.kff.org/content/2000/1574/VoterGuide.pdf

Your Guide to Health Issues in the 2000 Election

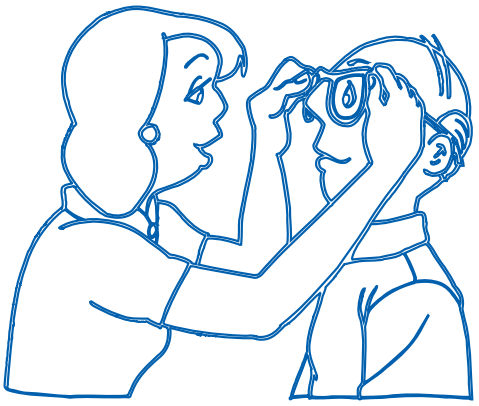
The League of Women Voters Education Fund and the Henry J. Kaiser Family Foundation joined together in a nonpartisan public education initiative to inform citizens, stimulate dialogue, and give the public a greater voice in the health care debate. The two groups provide "Join the Debate: Your Guide to Health Issues in the 2000 Election."

Calendar of Events

The Public Appearance Office lists no appearance events between July 17 and August 18.

HCFA Promotes Eye Exams for People with Diabetes

A cooperative effort to increase the dilated eye exam rate among Medicare beneficiaries with diabetes has been launched by the Health Care Financing Administration, the American Academy of Ophthalmology, and the American Optometric Association.



The joint initiative seeks to raise public awareness of the connection between diabetes and blindness, and attack barriers — such as payment and transportation issues — that prevent people with diabetes from getting dilated eye exams.

People with diabetes are at an increased risk for eye problems, including blindness, and may need treatment even if their vision is normal. About 10 percent of the Medicare population has diabetes.

HCFA has identified diabetes as a clinical priority area in which there is a significant opportunity to improve the quality of care provided to Medicare beneficiaries in all states across the nation.

Through its national network of Medicare Peer Review Organizations, who are committed to ensuring quality health care for Medicare beneficiaries, and in partnership with the AAO and AOA, HCFA hopes to positively

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influence the quality of care received by all Medicare beneficiaries with diabetes.

Medicare has provided a series of new or expanded preventive health care benefits since 1998, including mammograms, pap smears, colorectal cancer screening, bone mass measurement for beneficiaries at risk for osteoporosis and other bone abnormalities, flu and pneumonia vaccinations, glucose monitoring and education and training programs for diabetics.

By law, regular fee-for-service Medicare may not cover refractive services — eye exams for eyeglasses — although some Medicare+Choice managed care plans may offer them. Medicare does cover medical exams, however, and this new program makes it easier for diabetics to get regular medical eye checkups.

This campaign will provide information about the Foundation of the American Academy of Ophthalmology's EyeCare America — National Eye Care Project (NECP), a program that provides eye care for Medicare beneficiaries age 65 and older who have diabetes and who have not had a medical eye exam in the last three years.

NECP matches qualifying persons with a volunteer opthalmologist in their area who has agreed to provide a comprehensive medical eye exam and up to one year of follow-up care by the physician for any condition diagnosed at the initial exam, with no out-of-pocket expense to the patient, based on guidelines in an Office of Inspector General advisory opinion (OIG AO 99-7).

Medicare diabetes patients may also qualify for help in receiving an eye examination by calling AOA's Diabetes Hot Line. This program matches patients with a participating optometrist in their area who has agreed to perform a dilated eye examination and provide or arrange for subsequent care.

In cases of financial need, the optometrist may be able to waive the deductible and co-payment a Medicare patient usually pays.

Another barrier preventing Medicare patients with diabetes from receiving eye exams is lack of transportation. HCFA will address this barrier through its PROs. In some cases, PROs may be able to identify state or local community organizations that can provide transportation to eye appointments for Medicare beneficiaries.

PROs will inform Medicare beneficiaries of AAO's and AOA's programs through a series of postcards and brochures sent to qualifying beneficiaries. The project also features a national media campaign including radio and television public service announcements.

To learn more about the joint AAO/AOA/HCFA Diabetes Initiative, beneficiaries may call 1-888-691-9167. For more information about NECP, they may call 1-800-222-EYES (1-800-222-3937) 24 hours a day, seven days a week. AOA's Diabetes Hot Line is 1-800-262-3947. Operators are available from 6:00 a.m.-6:00 p.m. Eastern Standard Time Monday through Friday.

Contracts

Blue Cross and Blue Shield of Wisconsin to Replace Blue Cross of California As Medicare Contractor

The Health Care Financing Administration announced on May 3, 2000, that Blue Cross and Blue Shield United of Wisconsin will replace Blue Cross of California as the Medicare Part A contractor processing claims for hospitals in California, Hawaii and Nevada, and for home health agencies and hospices in eight western states.

Blue Cross and Blue Shield United of Wisconsin, which does business as United Government Services of Milwaukee, will assume the current workload of Blue Cross of California, also known as Wellpoint.

As the replacement Part A contractor, United Government Services will process claims for more than 300 hospitals, 1,100 nursing homes and other institutional providers in the three states and the Northern Marianna Islands, Guam, and American Samoa, serving about 4.3 million beneficiaries. Part A contractors, known as fiscal intermediaries, process claims for hospitals and other providers under contracts with HCFA, which runs the Medicare program.

Blue Cross of California, based in Thousand Oaks, Calif., notified HCFA in May that it would terminate its Medicare claims processing contracts with HCFA. The Blue Cross Blue Shield Association, which serves as the prime contractor for Part A claims processing with local Blue Cross plans, recommended the selection of United Government Services. HCFA accepted the Blue Cross Blue Shield Association's recommendation.

HCFA also designated United Government Services as the replacement regional home health intermediary to process claims for more than 700 home health agencies, as well as hospices, in Alaska, Arizona, California, Hawaii, Idaho, Oregon, Nevada, Washington and the three Pacific territories.

Health care for seniors and disabled people will not be affected by these changes. Providers can be assured that claims will continue to be paid promptly.

United Government Services will maintain offices in Camarillo and Oakland, Calif., the location of the current Medicare operations of Blue Cross of California.

The transition to United Government Services will be completed by December 1, 2000.

New York Selected to Process Medicare DME Claims in the Northeast

Blue Cross and Blue Shield of Western New York, operating as HealthNow NY, will replace United Health Group as the Medicare contractor processing durable medical equipment claims for the northeastern section of the country.

HCFA has established four durable medical equipment regional carriers (DMERC) which process claims for durable medical equipment, prosthetic devices, prosthetics, orthotics and other supplies provided to Medicare beneficiaries across the country.

HealthNow NY currently holds the contract for processing Part B Medicare claims for western New York and has Medicare operations in Binghamton, New York.

HealthNow NY will maintain DMERC offices in Nanticoke, Pa., and Meriden, Conn., where United Health Group is currently located. HealthNow NY has assured HCFA that it will make every effort to hire qualified Medicare employees from United Health Group as it assumes this work.

United Health Group, formerly known as United Health Care, advised HCFA in February of its decision to end its participation in the Medicare fee-for-service program to concentrate on other business priorities.

The northeastern region DMERC serves the states of Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont. Approximately 8.1 million Medicare beneficiaries reside in this area.

The transition to HealthNow NY is expected to be completed by September 30, 2000.

First Medicare+Choice Private Fee-for-Service Plan Approved

A request by the Sterling Life Insurance Company to offer the first private fee-for-service health plan option for people with Medicare, which will be available in 17 states, was approved by the Health Care Financing Administration recently.

The new Medicare+Choice plan will be available to beneficiaries beginning in July. Medicare beneficiaries who choose to enroll in the new private fee-for-service plan, Sterling Option I, will not be restricted to a network and may get health care services from any provider in the country who can be paid by Medicare.

A private fee-for-service plan is a private insurance program that charges enrollees a premium and cost-sharing amounts and lets beneficiaries choose the providers they want to see. In most cases, beneficiaries enrolled in the private fee-for-service plan will pay less to see a doctor than under original fee-for-service Medicare.

The Sterling Option I plan will furnish enrollees with coverage of all Medicare Part A and B services, and in addition will provide worldwide emergency care and coverage of increased inpatient hospital days. Providers who choose to provide care to beneficiaries enrolled in a private fee-for-service plan will be paid on a fee-for-service basis by the plan, and are not subject to utilization review.

The Sterling private fee-for-service plan will be available in Alaska, Idaho, Kentucky, Minnesota, Nebraska, New Mexico, Nevada, Oregon, South Dakota, Tennessee, and Utah. It will also be offered in selected counties in Arkansas, Louisiana, Mississippi, Ohio, Texas and West Virginia. The Sterling plan will be offered primarily in rural areas where Medicare+Choice options have not been widely available.

HMO Plan Offered to Medicare Beneficiaries in Five Florida Counties

The Health Care Financing Administration approved on May 25, 2000, a request by America's Health Choice Medical Plans Inc. to offer managed care coverage to Medicare beneficiaries in five South Florida counties.

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Congress created Medicare+Choice in the Balanced Budget Act of 1997 to expand the types of health care options available to Medicare beneficiaries. As part of Medicare+Choice, Medicare now offers new preventive benefits and patient protections, as well as a far-reaching information program that includes a national toll-free phone number — 1-800-MEDICARE (1-800-633-4227) — an Internet site — and a coalition of more than 200 national and local organizations to provide seniors more information. Medicare+Choice and private fee-for-service plans are available where private companies choose to offer them.

Currently, about 6.5 million Medicare beneficiaries — out of a total of nearly 40 million aged and disabled Americans — have enrolled in Medicare HMOs. Original fee-for-service Medicare, currently chosen by more than 33 million beneficiaries, is available to all beneficiaries.

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America's Health Choice Medical Plans, based in Vero Beach, Fla., began enrollment this past May to serve Medicare beneficiaries starting on July 1. The plan will be offered to beneficiaries throughout Indian River, Martin, Okeechobee and St. Lucie counties, and southern Brevard County, including the cities of Fort Pierce, Port St. Lucie, Sebastian and Vero Beach. About 113,000 Medicare beneficiaries live in the plan's newly approved service area.

HMO Plan Expands to Medicare Beneficiaries in Portage County, Ohio

A request by HomeTown Health Plan to expand managed care coverage to Medicare beneficiaries in Portage County, Ohio, was recently approved by the Health Care Financing Administration.

The plan, which does business as Secure Care, will continue to serve beneficiaries in six counties in the Akron-Canton area, including Holmes, Medina, Stark, Summit, Tuscarawas and Wayne. HomeTown began operating as a Medicare HMO in 1997.

Explore
www.medicare.gov

Commander Fay E. Baier, R.N., Is the Recipient of PHS' Outstanding Service Medal

Commander Fay E. Baier, nurse consultant with the Seattle Regional Office, received the U.S. Public Health Service's PHS Outstanding Service Medal for leadership and management responsibilities in carrying out HCFA's mission of assuring that high quality, fiscally prudent medical services are provided to Medicare beneficiaries. During an awards ceremony in Seattle on May 4, 2000, PHS Deputy Surgeon General Kenneth Moritsugu presented the award to Commander Baier.

Photo by David Haffie

Congratulations. (Left to Right): John Hammerlund, HCFA Deputy Regional Administrator, Seattle; PHS Deputy Surgeon General Kenneth Montsugu; Commander Fay Baier; Richard B. Lyons, M.D., PHS Regional Health Administrator; and Richard Kelly, DHHS Regional Director, Seattle.

Over the years, Commander Baier has consistently maintained performance above and beyond the requirements of her assignments. Commander Baier beg an her HCFA career in the Seattle Division of Clinical Standards and Quality, making valuable contributions to the Peer Review Organization program and the End-Stage Renal Disease core indicator project. Commander Baier became involved with the Medicare Part B medical review program in 1995, and she has represented the region on a regulation writing team for the Medicare Integrity Program, coordinated with consortium partners in managing medical review activities for six states, and facilitated developing medical review policies for 11 states in the Western Consortium.

Commander Baier has guided the Idaho Medicare Part B carrier in dealing with several unprecedented issues involving the Balanced Budget Act physician private contracting "opt out" provision and interpreting HCFA medical policy. She served as regional coordinator for the Correct Coding Initiative (CCI) since inception of the program in 1997. Commander Baier collaborated with other RO components to study the effect of Medicare payment policies in relieving inadequacies of rural health care, specifically, the status of Medicare's provision of bonus payments to physicians in PHS-designated health professional shortage areas. She has participated in PHS responses to emergency medical needs in 1995 in the British Virgin Islands after Hurricane Marilyn and in 1999 at Fort Dix to provide health care to Kosovo refugees, demonstrating her commitment to improving health care to needy populations.

Commander Baier's outstanding leadership abilities have resulted in the identification and recovery of millions of dollars in inappropriately claimed Medicare funds and the improvement of Medicare claim processing systems.

Article was contributed by Debborah Kozak, Chief of the Seattle RO's Program Integrity Branch, Division of Financial Management.

www.medicare.gov Improved Web Site Design Makes Medicare Information More Accessible

Medicare has added new and expanded information about Medicare benefits, nursing home staffing levels, health plan options and other topics to its popular ***www.medicare.gov*** Web site. The changes are part of a major redesign to make the Web site faster and easier to use.

The award-winning Web site, created by HCFA, now includes more features and information tailored to meet the needs of the growing number of older online users as well as family members and others who help them make their health care decisions, including:

> "These improvements to ***medicare.gov*** represent HCFA's latest commitment to help consumers make more informed health care decisions. Older Americans, their friends and their families are tapping into Web like never before."
>
> —NANCY-ANN DEPARLE
> HCFA Administrator

- A new site design that makes it easier to find, read and print online information about Medicare, including information on health plan options;
- New information about the number of plan members who have disenrolled from their Medicare+Choice plans. This information is compiled by HCFA and will be updated annually;
- New staffing information for nursing homes across the country which includes the number of registered nurses, licensed practical or vocational nurses and certified nursing assistants in each nursing home; and
- An improved screen reader that allows people with visual disabilities to access the Internet. This tool allows readers who have screen reader capabilities to "hear" the words on the screen.

The latest Medicare Current Beneficiary Survey showed that Internet access among people with Medicare who are 65 and older has skyrocketed from 6.8 percent in 1997 to 21.3 percent in 1999. In addition, industry figures on Web use indicate that people over the age of 50 represent the largest and fastest growing population on the Internet. They are increasingly usng computers and the Internet to search for information on vital issues like health care.

www.medicare.gov, which has already won awards for comprehensive content, is one of the Web sites providing information of interest to older adults. The site averages 7 million hits and 1.3 million page views per month.

HCFA's Web site contains useful information for people with Medicare and anyone involved in helping them with their health care decisions. ***www.medicare.gov*** is uniquely-designed to provide customized comparative information about Medicare+Choice plans (*Medicare Health Plan Compare*), nursing homes (*Nursing Home Compare*), supplemental insurance policies for people with Medicare (*Medigap Compare*), local events where Medicare is the topic (*Local Medicare Events*), and resources for additional information (*Helpful Contacts*).

"The latest upgraded site improvements include easier-to-access health-related information," DeParle said. "In addition, the new technologies we are using means that the page will load faster for people who use their telephone lines to access the Internet, helping them move faster through the site."

"The updated ***www.medicare.gov*** Web site also gives people with Medicare a listing of activities and meetings they can attend in their communities to learn more about their Medicare," said Carol Cronin, Director of HCFA's Center for Beneficiary Services. "Right now, there are more than 6,000 activities all around the country posted on the local Medicare events database."

HCFA originally launched ***www.medicare.gov*** in 1998. It is one part of the comprehensive National Medicare Education Program that also includes the *Medicare & You* handbook; 1-800-MEDICARE (1-800-633-4227); HCFA's toll-free telephone line; and partnerships with local and national organizations across the United States.

Payment Rates to Increase For Acute Care Hospitals

The Health Care Financing Administration, using payment change formulas established by budget laws in 1997 and 1999 recently said most acute care hospitals will receive a 2 percent increase in payment rates in Fiscal Year (FY) 2001.

The proposed rate increases are contained in a proposed rule that was published on May 5 in the *Federal Register* followed by a 60-day public comment period. The rate changes are based on a formula enacted into law.

The regulation updates prospective payment system (PPS) rates for acute care and specialty hospitals for the next fiscal year. The final rule is expected to be issued by August 1.

The Balanced Budget Act of 1997 specified an increase in FY 2001 of 1.1 percentage points less than the projected growth in the inflation rate for goods and services purchased by hospitals, known as the market basket. The increase in the FY 2001 market basket is estimated to be 3.1 percent for hospitals paid under PPS.

The proposed payment rate changes equal 2 percent for most acute care hospitals participating in Medicare and paid under Medicare's payment system. However, the Balanced Budget Refinement Act of 1999 specified that hospitals identified as the only provider of acute hospital services for a geographic area are to receive an increase equal to the market basket, a proposed change of 3.1 percent. Under PPS, Medicare pays hospitals a predetermined amount for each Medicare patient discharge based on the patient's diagnoses or procedures. Hospitals in large urban areas with a population greater than one million receive slightly higher payment rates than hospitals in other urban and rural areas.

The proposed FY 2001 payments to hospitals reflect the annual update to the wage index levels, calculated on the basis of FY 1997 wage data from short-term, acute care hospitals. HCFA also is proceeding with the second year of a five-year phase-out from the wage index calculation of costs associated with certain

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teaching physicians, residents and certified registered nurse anesthetists. These costs are paid by Medicare separately from PPS.

The proposed regulation does not expand the scope of the post-acute transfer policy enacted by the Balanced Budget Act of 1997. This policy reduces payments for hospital discharges from one of 10 diagnosis-related groups (DRGs) to a post-acute care facility such as a rehabilitation hospital or a skilled nursing facility. Congress authorized HCFA to expand the covered DRGs beyond the current 10, beginning in FY 2001, but HCFA has decided not to expand the policy at this time beyond the current 10 DRGs.

The proposed FY 2001 rate-of-increase limits on target amounts paid to specialty hospitals excluded from PPS are based on the increase in the market basket for these hospitals, currently estimated at 3.1 percent. These 3,400 specialty hospitals and hospital units include psychiatric, rehabilitation, long-term care, cancer and children's facilities. Changes in the target amounts for these hospitals would range from zero percent to 3.1 percent, depending on the relationship between the hospital's or unit's actual costs, and its predetermined target amount for the most recent available cost-reporting period.

New Regulations/Notices

Program Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update [HCFA–1112–P]—Published 4/10. This proposed rule sets forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for Fiscal Year 2001. Furthermore, it specifically proposes changes to the SNF/PPS case-mix methodology. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999, related to Medicare payments and consolidated billing for SNFs. In addition, this proposed rule sets forth certain conforming revisions to the regulations that are necessary in order to implement amendments made to the Act by section 103 of the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999.

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates [HCFA–1118–P] — Published 5/5. HCFA is proposing to revise the Medicare hospital inpatient prospective payment system for operating costs to implement applicable statutory requirements, including a number of provisions of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Public Law 106-113); and implement changes arising from our continuing experience with the system. In addition, in the Addendum to this proposed rule, HCFA is describing proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 2000. HCFA is also setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the prospective payment systems. HCFA is proposing changes to the policies governing payments to hospitals for the direct costs of graduate medical education and payments to disproportionate share hospitals, sole community hospitals, and critical access hospitals to implement changes made by Public Law 106-113. Finally, HCFA is proposing a new condition of participation on organ, tissue, and eye procurement for critical access hospitals that parallels the condition of participation that HCFA previously published for all other Medicare- participating hospitals.

Correction

In the article "Contractors Selected to Process Medicare Part B Claims in Five States" (June *Health Watch*), the 7th paragraph reads: "Following United Health Group's decision to leave the program, HCFA selected Empire Blue Cross and Blue Shield to process Part A claims in Michigan." The statement should have read: "Following United Health Group's decision to leave the program, HCFA selected Empire Blue Cross and Blue Shield to process Part A claims in New York and Connecticut, and United Government Services to process Part A claims in Michigan." An editor stopped at the first Part A in the original. When he resumed work, he searched for Part A again and inadvertently read from the second Part A. We apologize for the error.

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